



Child Care Program Request to Administer Medication

I hereby request and give permission to City of Englewood KidConnections Summer Camp to administer medication to the child identified by this form. I understand that it is my responsibility to provide the medication in the original pharmacy labeled container.

Name _____ Birth Date _____

Program _____ Name of Physician _____

Medication _____ Time to be Administered _____ May repeat every _____ hours

Dosage (mg) _____

Reasons for medicine: Exact Temperature _____ Pain _____ Other _____

Route _____

Period of time for medication to be administered: From _____ To _____

Note: The form is valid for a maximum of one (1) year.

Possible side effects _____

Signature of person with prescriptive authority: _____

Physician's Address

Phone #

Fax #

I acknowledge that the administration of this medication by KidConnections personnel is an accommodation performed solely upon request. In consideration of the acceptance of this request, I release and waive any claims which I now have or may have hereafter against City of Englewood and its employees which may arise from the administration of or the failure to administer the medication to the child or any adverse reaction by the child to the medication.

Parent or Legal Guardian Signature

Date

Date	Type of Medication	Dosage	Time Administered	Signature

[illegible]